

## Chapter 4

# **Socially Determined Perceptions of Risk are Reflected in the Decision to Request a Second Opinion Appointed Doctor's Visit**

### **Introduction**

A central feature of providing for people with mental health difficulties is the occasional need to consider imposing treatment upon an individual in the absence of their informed consent. Historically patients suffering with mental health problems were considered to lack the necessary judgement or capacity to give true consent. It was not until the 1820s, enlightened by the memoirs of a patient, that awareness of consent became the subject of debate (Perceval, 1982). Furthermore, it was not until the 1970s that the assumption that detained patients could be treated for their mental disorder without consent met serious challenges. The subsequent debate led to the provisions of Part IV of the Mental Health Act 1983, which stipulates safeguards against the inappropriate treatment of non-consenting detained patients. In particular these include the need for treatment plans to be endorsed by a second medical opinion. Current debate and further reform of mental health legislation consider two different sets of circumstances in which treatment without consent might be appropriate. These are either a situation in which a person is considered too psychologically disabled to give fully informed consent (lacks capacity), or circumstances in which a failure to be treated despite lack of consent would put the patient and/or others at risk. Some attempts have been made to clarify how capacity might be determined and assessed. The Law Commission attempted a definition of capacity, which recommends the assessment of five key areas (Law Commission, 1993):

- Communicating a choice – the ability to make a response about a particular decision;
- Understanding information relevant to the treatment – albeit in ‘broad terms’ and ‘simple language’;
- Retaining information – if information is not retained, the individual is unlikely to understand relevant information;
- Manipulating information rationally – the ability to weigh the risks and benefits of different options;

- Appreciating the situation and its likely consequences – the individual recognises the disorder for which treatment will apply.

These reflect recent views that the right to self-determination is only meaningful if the person is appropriately informed, is free to make decisions without coercion and has the ability or 'capacity' to make the decision. Where an individual is considered to lack capacity, the individual's need for care and protection from harm supersede considerations of the respect for autonomy (Wong et al., 1999).

Resolution of this tension between respect for autonomy and an individual's need for care routinely relies upon judgements made by medical practitioners and approved social workers. The professional practitioner is primarily responsible for determining whether or not the patient has the capacity to give or withhold consent, and also for defining their 'best interests'.

An important facet of 'best interests' is the notion that psychologically disabled patients can unwittingly be at risk to themselves or to others. Thus, in addition to making judgements about individuals' ability to understand information, consider options and appraise the possible outcomes of treatment, practitioners are also called upon to make a judgement about the extent to which an individual is putting themselves or others at risk. Consideration is given to the possibilities of deliberate self-harm, recklessness, self-neglect, or the extent to which there is risk of violence or dangerousness towards others, or exploitation by them. Thus professional judgements of whether or not a detained patient might be treated against their consent are not only an appraisal of their ability to make an informed decision about the need for treatment but also an appraisal of the risk of self-harm or violence if treatment is not carried out. This could explain why rates of detention deviate from population norms in ways which some suggest reflect a tendency to view certain sections of society as particularly threatening. Noble and Rogers reported a longitudinal record of violent incidents in the Bethlem Royal and Maudsley hospitals in London, and found that in their control group of non-violent patients, 50% of Afro-Caribbeans in the sample were detained formally on locked wards, whereas only 15% of non-violent White patients were managed in the same way (Noble and Rogers, 1989). Black patients were also recorded as being more violent than White patients. Other investigators of this area have emphasised the need to recognise and respect the effects of cultural distinctions upon the use of services by those of Afro-Caribbean origin (Harrison et al., 1988a).

Such issues underline the importance of considering the relationship between ethnicity and psychiatry, particularly in relation to compulsory admission and treatment without consent. We have used an opportunity to investigate this from the perspective of the Mental Health Act Commission (MHAC) which collects information about patients visited to consider treatment in circumstances where informed consent is not available.

## **Method**

In addition to its visiting programme the Mental Health Act Commission (MHAC) administers the activities of Second Opinion Appointed Doctors (SOADs). These independent appointees of the Secretary of State review treatment plans for patients in whom the Responsible Medical Officer (RMO) proposes a treatment that requires either consent or a second opinion (Section 58) in circumstances where informed consent is not available, or a treatment that requires both consent and a second opinion (Section 57).

In recent years summary details about patients who have been the subject of such second opinion reviews have been collated by the MHAC as an electronic database. By February 1999 it had accumulated information about 15,466 such visits in the form of 48 variables including: details of ethnicity, gender, age, treatment with ECT and/or medication, Mental Health Act category of illness, whether the patient was deemed incapable of giving consent to treatment or was refusing treatment, section of the Mental Health Act under which detained, and limited geographical information in the form of the Commission Visiting Team catchment area of the visit. We have analysed data from the period March 1997 to February 1999.

The original database was held by the MHAC as an independent mainframe UNIX system. It was exported by tape and reformatted as SPSS, version 8. There was a significant but not disabling rate of missing values (mean rate of missing data per variable 2.5%; range 10.3% (ethnicity) – zero (age and sex)). Extra variables were created classifying ethnicity and age according to the official census categories.

Frequency analysis was used when appropriate, drawing expected frequencies from national statistics of age, gender and ethnicity provided by the Office of National Statistics (ONS) and the Office of Population Census and Surveys (OPCS) (1991 Census).

## **Results**

The database contained information about almost equal numbers of men and women (8,213; 53.1%, 7,234; 46.9% respectively). There were striking differences in the age distribution within each of the genders. Of the male patients, 64.3% were under 40 years of age and 83.7% were under 55. For female patients, 82.7% were over 40 years of age and 62.1% were over 55. Males 17-44 years of age were twice as likely as females of the same age to attract a second opinion visit to consider treatment without consent whereas females 64-85 years of age were twice as likely as males of the same age to attract such a visit.

Table 4 gives these age distributions and compares them with those of the general population, defined by the 1991 Census.

**Table 4: Gender distribution by age category (% population)**

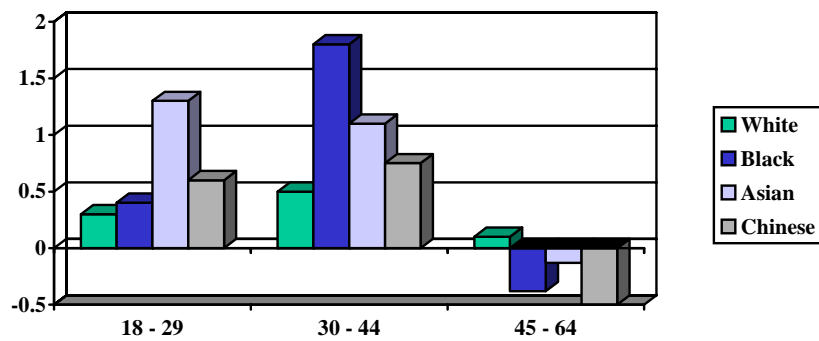
Age Category	Gender			
	Male		Female	
	SOAD Visit	OPCS	SOAD Visit	OPCS
17 and under	1.0	23.8	1.0	20.5
18-29	25.6	19.5	12.9	17.1
30-44	37.7	21.8	24.5	19.9
45-64	21.4	23.3	26.1	21.6
65-74	7.1	8.3	14.8	9.2
75-84	5.8	4.2	14.7	7.5
85 and over	1.5	0.7	6.0	2.1

Predictably there is considerable under-representation in the 17 and under age group; altogether there were only 277 second opinion visits to persons under the age of 18. Amongst the older age groups there is evidence of over-representation in the 30-44 age range, which was more pronounced amongst men ( $\chi^2 = p < 0.001$ ) and amongst females in the over 65s ( $\chi^2 = p < .001$ ).

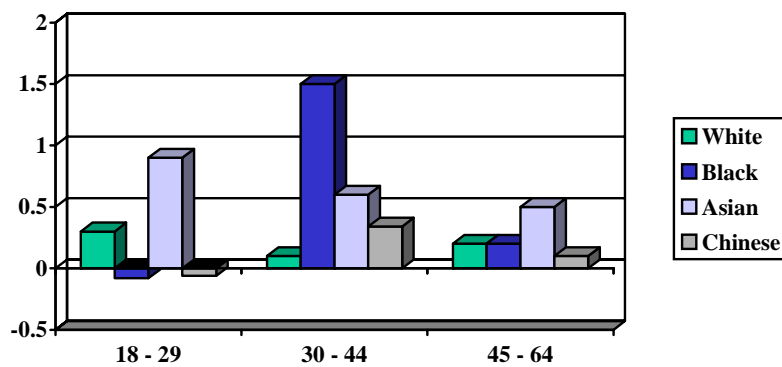
Figures 4 and 5 illustrate the ethnic composition of the study population by reference to the 1991 Census. They show, for males and females respectively, the relative difference between the proportion of the population of the second opinion visited patients of a given ethnic background and age band, and the proportion of the general population similarly defined. Later age bands have been omitted because of small numbers: less than 3.5% of the total. These relative differences illustrate the degree to which different age/gender/ethnic background-defined groups of patients were under- or over-represented in the SOAD visit sample. Amongst the males over-representation (Deviation  $> 0$ ) in the 18-29 and 30-44 age ranges is more pronounced amongst those from non-White backgrounds, whereas the converse was true amongst the 45-64 year olds. Amongst the females over-representation in the younger age ranges, though less than amongst the males overall, was also more pronounced amongst patients from Black and Asian backgrounds. Amongst females at the older end of the age range there was over-representation of all ethnic groups.

There were almost equal numbers of visits for issues concerning capacity to give consent as there were for issues concerning refusal to accept treatment, but these had different age and gender distributions which are illustrated in Tables 5 and 6. Differences between the figures in this table and the total numbers of males and females in the sample, 34 males and nine females, are due to missing data.

**Figure 4:** Deviation from parity in the ratio between the proportion of the population of the SOAD database of a given ethnic background and age band and the proportion of the general population similarly defined: Males



**Figure 5:** Deviations from parity in the ratio between the proportion of the population of the SOAD database of a given ethnic background and age band and the proportion of the general population similarly defined: Females



**Table 5: Reasons for SOAD visit to consider consent to treatment by age category**

Age category	Gender			
	Male		Female	
	Incapable	Refuse	Incapable	Refuse
17 and under	50	28	25	46
18-29	901	1196	394	541
30-44	1265	1809	756	1010
45-64	884	869	923	964
65-74	360	220	638	437
75-84	353	123	721	342
85 and over	99	22	310	118
Total	3912	4267	3767	3458

1171 visits were made to consider the treatment of patients with doses of medication above recommended BNF limits. Males were twice as more likely (797:374) to fall into this category than the gender distribution of the whole sample would predict ( $\chi^2$ ;  $p < .001$ ). Furthermore there was a significantly higher probability of these considerations applying to patients from minority ethnic groups, which is illustrated in Table 4.3 ( $\chi^2$ ;  $p < 0.001$  both genders). Differences between the figures in this table and the overall number of males and females being visited to consider the use of drugs above BNF limits are also attributable to missing data.

**Table 6: Observed and expected frequencies of Whites and Non-Whites considered for the use of drug treatments above BNF limits**

	Males		Females	
	Observed	Expected	Observed	Expected
White	541	581.4	279	301.6
Non white	217	176.6	63	40.3

Comparisons between the 1,589 patients in whom ethnicity was not recorded and the 13,877 in which it was recorded revealed no differences in age or gender distribution, reasons for the visit or the nature of failure to consent.

## **Discussion**

These findings are taken from analysis of a robust database. Review of treatment for mental illness without informed consent by a second opinion appointed doctor is a statutory requirement. The source of this information was a database compiled by the body administering those reviews across England and Wales during a two year period and is therefore as good a reflection of the characteristics of patients attracting such visits as can be obtained. Although 10.3% of ethnicity data were missing from the sample there is no evidence that these missing values were from patients in any way different from the sample as a whole.

The main findings are differing age distributions for patients from the two genders with a tendency for male patients to fall into the under 45 age range, contrasted with a more even distribution across the age range for females. Compared with population statistics there was significant over-representation amongst male patients attracting a SOAD visit in the 18-44 age range, and amongst female patients in the 65+ age range.

When the ethnic origin of patients attracting a SOAD visit was considered by comparing the ethnic composition of the sample population with population statistics there was evidence of an over-representation of younger people from the ethnic minorities of both genders. In contrast the over-representation of elderly females in the sample appears to reflect an over-representation of elderly females from all racial backgrounds.

There is already evidence that people from ethnic minority backgrounds, particularly those born in Britain, are more likely to be diagnosed as suffering Schizophrenia, more likely to be compulsorily admitted to a psychiatric hospital, more likely to be treated in conditions of security and more likely to be given large doses of medication than population statistics would predict (Fennel, 1996). Our findings extend this, confirming the fact that this over-representation includes the use of treatments without consent. Thus, these data are further evidence of an enhanced tendency for young males, particularly those from a minority ethnic background, to find themselves subject to detention under the Mental Health Act and treated without consent than the composition of the general population would predict. Fennel referred to concerns that this might be the case in his earlier report of second opinion visits, and indeed those concerns led to the improved quality of recording ethnicity that this report has been able to take advantage of.

These data also suggest that these over-represented instances of the need to consider treatment without consent amongst younger people are caused by the need to consider circumstances in which a treatment is considered desirable but it is being refused, rather than circumstances in which a treatment is considered desirable and the patient is considered incapable of providing informed consent. A strong inference is that these reflect circumstances in which it is felt desirable to influence patients' behaviour because it is thought to be risky or dangerous, and that inference is perhaps further supported by the finding of an additional tendency

to consider the use of neuroleptic medication at doses above recommended limits. Reasons why this might be the case, especially amongst young men from ethnic minority backgrounds are presumably similar to those behind the higher rates of diagnosing Schizophrenia referred to above, and already the subject of a widespread but inconclusive debate around possible explanations. One is that there are higher rates of social disadvantage amongst those from ethnic minority backgrounds. The Fourth National Survey, which measured the socio-economic status of ethnic minorities using three indicators, social class, unemployment rate, and quality of housing, identified the Pakistani and Bangladeshi populations as the most disadvantaged ethnic minority groups (Nazroo, 1997). However these ethnic minority groups do not appear to have rates of mental illness as high as those within the Black population. Although research within this area has produced conflicting results it is clear that determinants of a high rate of reported psychosis amongst the Black population are more complex than social deprivation alone can explain. Nevertheless Sashidharan strongly discourages dismissing the argument that the relationship between ethnicity and health is a consequence of social disadvantage. Theories suggesting psychiatric disorders to be a consequence of inherent and stable characteristics of certain ethnic minority groups are not only so far untested, but could lead to the cultural and biological heritage of these groups becoming pathologised (Sashidharan, 1993).

Other research has suggested that high rates of Schizophrenia amongst the Black population are the result of stress and other more indirect consequences of social disadvantage (Harrison et al., 1989). As stress and anxiety rates within the Black population appear to be lower than for other ethnic minority groups (Lloyd, 1993), it has also been suggested that high rates of Schizophrenia are related to migration rather than social disadvantage (Sashidharan, 1993). This view is supported by reports of lower rates of Schizophrenia in the West Indies compared to those of the Black population in Britain (Bhugra et al., 1989). This appears to indicate that the process of migration or the way of life upon settlement in Britain affects the rates of Schizophrenia. However, studies have also shown that other ethnic minorities do not have similar rates (Busfield, 1999). Furthermore, the higher rates amongst those born in Britain suggest that there is little to connect the process of migration or straightforward biological or genetic differences to high rates of Schizophrenia. They indicate other factors must be relevant to the increase for the Black population born in Britain. Jenkins states that:

“it is possible, however, that the particular and different ways in which ethnic minority groups are racialised could lead to different outcomes for different groups” (Jenkins et al., 1997).

Furthermore the association between Schizophrenia and violence or other forms of dangerous behaviour links violence and dangerous behaviour not only to Black males within mental health in general but also specifically within the population of patients who are detained and, in particular, do not comply to consent to treatment



(Cope, 1989). Some suggest that a diagnosis of Schizophrenia automatically labels the patient as dangerous or violent, especially in those cases involving males from amongst the Black population (Boyle, 1990).

This draws attention to the need to acknowledge the way in which culture determines rates of illness and raises the question of how much of a particular diagnosis is based on perceptions of illness, characteristics of the individual patient or misunderstandings about minority cultures.

Cultural dimensions of illness within Western bio-medicine, or what has been called the 'category fallacy' (Kleinman, 1980), have lead to cross-cultural comparisons of mental health. This amounts to:

"the reification of a nosological category developed for a particular cultural group that is then applied to members of another culture for whom it lacks coherence and its validity has not been established" (Mirowsky and Ross, 1989).

The judgement of whether behaviours and actions are symptomatic of abnormal mental health requires, he argues, knowledge of their social and cultural context. Within psychiatry, the definition of disease and dysfunction is often very unclear.

"Cultural factors play a far more significant role in the recognition of mental disorders than they do in physical illness. What may be considered as a departure from normative behaviour in one culture may not have the same meaning when applied to another culture" (Bentall, 1988).

We have presented data from a robust source that clearly illustrates an unrepresentative tendency to use statutory powers that enable treatment without consent upon young males, and to a degree, young males and females from ethnic minority backgrounds. A brief review of possible explanations for an over-representation of persons from ethnic minority backgrounds amongst those detained under the Mental Health Act suggests that simple factors such as an inheritable propensity, or a direct association with social disadvantage, or 'stress' do not provide an adequate explanation. That it is not just individuals from ethnic minorities that are over-represented amongst those being considered for treatment without consent, but just as strikingly, young males of all races suggests that it is more likely that this over-representation reflects real or perceived risks of violence occurring in the context of what might be construed as mental illness.

There are culturally bound determinants of the response to different forms of dangerousness and these inevitably influence professional judgements. Pilgrim and Rogers suggest that "professionals have an interest in maintaining a construct which in common cultural currency equates mental illness with violence" (Pilgrim and Rogers, 1999). They also argue that this common perception, that the mentally ill are more aggressive, is driven by the media. The influence of the media in shaping views about violence and mental disorder has increasingly been a cause of

great concern. Philo reported that two-thirds of items dealing with mental health issues forged a link with mental illness and violence (Philo et al., 1994). These judgements are also influenced by a public perception of the young black male as a more dangerous person. It is the male Afro-Caribbean community, fuelled by the media publicity of particular incidents, which is more likely to be linked with crime and violence (Ritchie et al., 1994).

That this ethnic bias appears to be reflected in rates of detention under powers of the Mental Health Act and rates of treatment without consent suggests that practitioners administering Mental Health Act procedures are themselves not immune to these public perceptions; indeed it has long been argued that maintaining a social order based upon shared perception is part of their legitimate role (Porter, 1987). Similarly O'Malley has argued that the welfare state is changing its role in response to the development of a risk society (O'Malley, 1991) whereby the role of the state is to protect citizens against risks perceived as unpredictable. It would seem that the behaviour of certain subgroups of individuals deemed to be dangerous by virtue of mental illness falls into this category.

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